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PHILADELPHIA, JULY 7, 1877.

ORIGINAL LECTURES.

CLINICAL LECTURE

ON A CASE OF PERINEAL SECTION.

BY J. WM. WHITE, M.D.,

Surgeon to the Philadelphia Hospital.

Reported by J. Monro Murray, M.D.

GENTLEMEN,—J. H., colored, æt. 45, was admitted to the wards of this hospital a few weeks ago, suffering from a condition of affairs to which I now call your attention.

In general appearance he is emaciated, feeble, cachectic; his cheeks are sunken, his tongue, when protruded, is seen to be dark, coated, and tremulous; his countenance is anxious and expressive of suffering. On examination his heart and lungs are found to be healthy, pulse 105, no general abdominal tenderness and no tympany; pain on firm pressure over the hypogastrium. On elevating his scrotum there are seen about the peno-scrotal junction four small, depressed apertures, from which a muco-purulent secretion is flowing. On asking him to empty his bladder you observe a mixture of pus and urine issue from each of these fistulæ, and by questioning we elicit the following history, which the patient gives clearly and intelligently. About fifteen years ago he had several attacks of gonorrhœa; a few years later he noticed that he had some difficulty in making water, which difficulty, after a period of intemperate living, so rapidly increased that he went to a hospital. A medium-sized catheter was passed a few times, and he was discharged, with instructions to pass the instrument for himself occasionally. He left the city, taking a catheter with him, and soon afterwards had an attack of complete retention of urine; he made several ineffectual attempts to introduce the catheter, which was, according to his account, about No. 15 of the French scale. He gave himself a great deal of pain, and did not succeed in drawing off his urine, but some hours later a slight dribbling occurred, giving him temporary relief. In a day or two a swelling appeared in the perineum, suppurated, discharged spontaneously, and left the largest of the fistulæ which you see here. Since that time, some twelve or fourteen years ago, not one drop of urine has passed through the penis, the bladder emptying or partly emptying itself through the perineal openings. His general health has steadily decreased. His urine contains large quantities of pus, and consequently of albumen, and is strongly ammoniacal, but no tube-casts have been detected after several careful examinations.

Rapidly recalling the salient points, we find that they are as follows: Gonorrhœa, stricture (improperly treated by incomplete dilatation), probable formation of a false passage by the patient's attempts at catheterism, extravasation of urine, perineal abscess and fistula (followed by complete obliteration of the urethral canal from a deposit of cicatricial tissue), cystitis, and gradual exhaustion from long-continued irritative or suppurative fever.

The case is one of extreme interest for many reasons, to the principal of which I shall briefly direct your attention. In the first place it is instructive as a specimen of the possible sequelæ of the timid and ineffectual treatment of stricture which is too often adopted. To discharge as cured an ignorant patient with instructions to pass a No. 15 instrument upon himself, the normal calibre of his urethra being at least 28, is to ignore not only the more recent advances in urethral surgery, but even its first principles. The result also teaches the great danger of allowing such patients to use solid instruments even of 15 millimetres in circumference.

Strictures are most frequently situated at the sub-pubic curvature, as in this instance, and then awkwardness in the use of an instrument is especially dangerous. The resistance offered by the triangular ligament during micturition to the expansion of the urethra becomes a persistent cause of irritation when there is increased vascularity of the mucous membrane, as in gleet, and consequently determines in many cases the seat of contraction.

Never consider a patient with urethral stricture as *cured*, or even as out of danger, unless the instrument which can be passed into the bladder is fully equal to the normal calibre of the urethra. The cystitis and suppuration which have followed the imperfect emptying of the bladder through these very contracted openings may result from a much less interference with micturition,—a fact which should never be absent from your mind when you come to take charge of such cases.

Since the patient's admission to the hospital he has been put upon generous diet, with quinine, and a moderate amount of alcoholic stimulus. Repeated, careful, and patient efforts have been made to enter the

bladder through the normal channel; every variety of instrument has been used, the patient has been etherized, and the sittings have been as frequent and as prolonged as was at all consistent with his safety, but without result. You have probably heard surgeons remark that they had never failed to pass a bougie or catheter, and have, consequently, never had to resort to any very serious operation for the relief of stricture of the urethra. If their practice has been extensive, their pride in this circumstance is very excusable, and arises from the fact that patience and perseverance have been found to accomplish so much in many apparently hopeless cases. If this patient were able to pass any water whatever, even a single drop, through this stricture, I should feel certain that by time and trouble I could get into his bladder, and I would not now be justified in ceasing my attempts. But we have here a canal which has been hermetically sealed to the passage of fluids for at least twelve years, and the normal structures of which have probably been entirely obliterated. I am convinced that if success in this direction were possible, it would have been attained by the many efforts made by myself and colleagues, and therefore we may finally abandon the idea of relieving the patient in this manner. Our efforts to introduce a probe into the bladder through any of the fistulæ have also resulted in failure. The sinuses are small, tortuous, and through tissues thickened and hardened by plastic exudation.

The operation which, under these circumstances, seems most likely to ameliorate the patient's condition, is the one known as perineal section, and may be briefly described as follows: A large staff is passed down to the stricture; an incision is made in the median line of the perineum, the end of the staff is exposed by free incision through the constriction, and an attempt is then made to find the posterior portion of the urethra by careful dissection. If successful, the staff is passed along it into the bladder; if not, as is commonly the case, a new channel must be made through the brawny and indurated tissue and kept pervious by the retention or frequent passage of a catheter. The operation should be distinguished from that of external urethrotomy, which is done on a grooved staff in cases of *permeable* stricture.

The dangers attending this procedure are evident: urinary infiltration, hemorrhage, pyæmia, a variety of accidents, may carry off your patient; and the question arises, Is this man in a proper condition to undergo such an ordeal? The fact that his troubles are largely due to incomplete micturition, and that he needs especially a full, free outlet for the urine, has decided us in favor of the operation, the shock of which would not be appreciably greater than that of a free perineal opening, nor, indeed, than that of supra-pubic or rectal puncture of the bladder. These measures, however, are purely palliative, while by the successful performance of perineal section I may restore him to a comparatively healthy condition. It must be admitted that the prognosis is decidedly unfavorable; but the man is anxious for the operation; his life is almost unbearable at present, and could not be long protracted; there is at least a possibility of success; there is no evidence of any organic disease except that depending directly upon the urethral and cystic troubles, and there are instances of almost complete cure in even more unpromising cases.

[The operation was performed in the usual manner, and the entrance to the bladder was discovered after a long and troublesome dissection. The constricting bands were freely divided, and a No. 22 silver catheter was left in the bladder. There was no serious hemorrhage.]

The subsequent progress of the case was as follows:

The patient was given full doses of a mixture containing quinine, salicylic acid, and opium, and was placed upon extra diet. On the evening after the operation (March 24) he suddenly became delirious, jumped from the window of the ward (fortunately on the ground floor), and ran several hundred yards before he was overtaken. The catheter, which was held in place by tapes and adhesive strips, did not fall out. The following morning (March 25) he was entirely rational and in good spirits. Pulse, 88; respiration, 22; temperature, 99.4°.

March 26.—Slight accession of fever; great hypogastric tenderness; catheter withdrawn; warm hop-poultices applied over abdomen and changed every three hours; urine escaping freely through incision.

27th.—Pulse, 100; respiration, 16; temperature, 99.8°. Wound looking healthy; less pain; gave rectal injection of sweet-oil and soap-suds.

28th.—Pulse, 90; respiration, 18; temperature, 98.4°. Appetite good; no pain; bowels opened naturally.

29th.—Pulse, 89; respiration, 18; temperature, 98.2°.

Fearing a complete closure of the urinary channel by granulations, Dr. White re-introduced a catheter with some difficulty; immediately after its insertion, a small quantity of tolerably clear urine passed from it, and the amount was increased when the patient strained or when pressure was made over the hypogastrium. During the rest of the day he complained of severe pain. The three fistulæ which were not included in the incision had entirely closed at this time.

30th.—Pulse, 114; respiration, 30; temperature, 101°. A decided change for the worse; hypogastric and abdominal pain intense. Believing that the catheter was the cause of this exacerbation, it was at once withdrawn, when defervescence gradually took place. It was followed, however, by a period of intense depression, so that on April 1 his pulse was only 60, respiration 20, and temperature 97°. Carbonate of ammonium and whisky were freely given, and in about twenty-four hours he reacted strongly, the temperature rising to 102°, and the pulse to 130. After this there was a return to an almost normal state, and then for six or seven weeks his condition varied, but he gradually lost strength, and died May 19.

On Saturday, May 26, after reminding the class of the case, which had been before them several times during its progress, Dr. White made the following remarks:

The fatal termination of this case has given me an opportunity to illustrate its pathology, and to explain some symptoms the causes of which during life have been obscure. Let us briefly review the record of the case. We first notice a temporary intense delirium occurring suddenly within a few hours of the operation, and disappearing with equal suddenness. This was probably an instance of traumatic mania, a not uncommon complication of extensive operations and severe accidents. It generally, however, persists for a few days, and requires depletory measures for its removal, but in this case ceased spontaneously and almost immediately. There were no troublesome symptoms for two days, when hypogastric pain and abdominal tenderness came on, but were immediately relieved by the withdrawal of the catheter. Authorities differ as to the retention or non-retention of an instrument in the bladder after this operation. The danger of retention is chiefly cystitis; the dangers of non-retention are urinary infiltration from the greater exposure of a large absorbing surface, and also the possibility of a sudden closure by granulations or cicatrization of the posterior portion of the urethra which has just been discovered or tunnelled out. So far as the result goes, I regret exceedingly that in this case I suffered the instrument to remain in, and I also regret its re-introduction a few days later, to which many unfavorable symptoms seemed referable.

Let me at this point read you the notes of the post-mortem examination, and show you the penis, bladder, and prostate gland which I have here.

Autopsy, eighteen hours after death.—Body much emaciated; silver catheter No. 15 French passed to sub-pubic curvature meets with insurmountable resistance. One large opening in median line of perineum corresponding to the incision made at the time of operation; scars of three fistulæ near same region (entirely closed); just within the opening in the median line were the orifices of two separate fistulous tracts, one leading directly to the bladder, the other running off to the side, and communicating with a large ischio-rectal abscess, containing eight or ten ounces of pus and urine, completely surrounding the rectum and extending upwards as high as the promontory of the sacrum. No communication whatever existed between this abscess-cavity and the rectum; the wall between the two sinuses, one leading to the bladder and the other to the abscess, was also entirely impervious. On cutting down upon the end of the catheter, it was found surrounded by a dense mass of cicatricial tissue. The pelvic fascia was thickened, injected, and everywhere adherent. The recto-vesical pouch of peritoneum showed inflammatory changes, but there was no evidence of general peritonitis, and no pus was found in the abdominal cavity. The bladder was contracted, hypertrophied, ribbed; the mucous membrane thickened, intensely congested and eroded; the prostate gland was somewhat enlarged and indurated, but no false passages were found in it.

Now, were the ischio-rectal abscess and pelvic cellulitis, which were the cause of death, in any way attributable to surgical interference? I am inclined to think they were, and, on looking back now with the additional light thrown upon the case by the autopsy, I read it in this wise. The patient during his attempts at catheterization made a false passage leading into the ischio-rectal fossa. At the time of operation this was not noticed, or was mistaken for one of the urinary fistulæ. During my manipulations when re-introducing the catheter, I probably reopened the orifice of this sinus, which the post-mortem shows to be alongside of the one leading to the

bladder. That I did not *make* this sinus or false passage myself I knew from the following facts: my instrument, when introduced, was directly in the median line; its point was freely movable, the ribbed surfaces of the bladder could be felt, and urine issued from it after its insertion. At the next and at subsequent attempts at micturition urine found its way into this now patulous canal, thence into the ischio-rectal fossa, and, by its presence and decomposition, became a source of irritation, and finally of death. If I had let this man alone after the first withdrawal of the catheter it is highly probable that the sinus which was then closed would have remained so, and this accident would not have occurred; so, although of course my motives were good, I am compelled to believe the re-introduction of the catheter to have been an error of judgment.

Subsequent to this time the temperature sheet, which you see here, shows the daily recurrence of hot spells alternating with an almost normal temperature, and this regular zigzag line is almost pathognomonic of hectic or suppurative fever.

As a result of the existing pelvic cellulitis, he had extreme abdominal tenderness and tympany, and he also suffered from obstinate and distressing hiccough, probably caused by the distention of the abdomen. He had an occasional free evacuation of pus mixed with urine, particularly when he assumed the erect posture; this was due to an overflow from the abscess, which I have described to you, and which might possibly have been punctured per rectum with advantage. The patient, however, when this condition was suspected, was so utterly broken down that no interference was deemed justifiable, particularly as the emptying of the abscess-cavity was erroneously supposed to be nearly or quite perfect.

The case has in many ways been a most interesting one, and is full of instructive and important lessons; and, although I heartily regret its unfortunate termination, I am glad to have had an opportunity of presenting it to you in such detail and with such completeness.

Mr. Henry Smith has been appointed Professor of Systematic Surgery in King's College, London, in lieu of Mr. John Wood, resigned.

ORIGINAL COMMUNICATIONS.

STRANGULATED HERNIA, WITH CASES AND REMARKS UPON OPERATIVE PROCEDURE IN CASE OF DOUBTFUL DIAGNOSIS.

BY OSCAR H. ALLIS, M.D.,
Surgeon to the Presbyterian Hospital.

THE history of cases is an important but not always an interesting feature in medical articles; still, as in three of the following cases there was in each an error, either in the *diagnosis* or in *practice*, a proper decision can only be arrived at by quite fully stating them. I shall after each defend the course pursued, and at the same time point out the source of error. Such a course is, I think, a fair and honest way of presenting cases. "We all learn by our mistakes," but it is a sad commentary upon the high position of our profession that successes are often *published*, leaving others to repeat the *unpublished* mistakes.

Had the responsibility of the following cases rested solely upon my own decision, I still should feel it a duty to publish them; but as able and experienced physicians and surgeons were associated with me in them all, I am confident that the difficulty in the diagnosis or the reasons for the fatal or unfortunate delay will be accorded, even if it does not seem so plain from the narrative.

Case I.—John W., aged 59, Irish, married, healthy, a carpet-weaver. Two or three weeks previous to his attack of hernia had been considerably reduced by a persistent diarrhœa.

On Tuesday, September 29, went to market, purchased a bushel and a quarter of potatoes, and in attempting to carry them to the street-cars he experienced a sudden pain in the right groin. The pain was not immediately severe, and on his return home he went to the shop to work. The pain soon became severe, and he returned home.

The pain continued, and a surgeon (Dr. K.) was called in on the following day. He found nothing serious in the case, and did not return. On Thursday, a physician from a neighboring hospital was called in, who immediately recognized, *as he thought*, a hernia, obtained assistance, administered ether, and reduced the size of the tumor, but not to his entire satisfaction. As he could not see the case again he requested me to visit and take charge of it. I saw him on Thursday evening, October 1, sixty hours from the attack.

Condition since seizure.—There has been persistent pain in right groin since Tuesday

morning, vomiting more or less frequent from the first, no movement of the bowels, constant thirst, but fluids taken immediately vomited, colored with bile. Pain (at my visit) extreme; face anxious, pinched, pulse frequent and feeble, belly distended and tympanitic, tongue moist and heavily coated with brown fur.

On examining the suspected parts, I found the right testicle drawn up to the mouth of the inguinal canal, swollen to nearly twice its normal size, and so exquisitely sensitive as to preclude any but the most gentle handling. The other testis was atrophied. There was a slight swelling along the course of the inguinal canal. This swelling was continuous with the testicle, and seemed to be the inflamed cord.

On the following morning (Friday), I called in consultation Dr. K. (the one who first saw the case). He assured me that there was no evidence of a hernia at his first visit, but that the physician who had subsequently visited him had been making unsuccessful attempts to push a testicle up into the inguinal canal, and that the resulting orchitis was the efficient cause of the peritonitis and the concomitant symptoms.

Friday evening.—Bowels still unmoved, vomiting persistent, testis still retracted but less swollen and tender. Vomited matter dark, shreddy, no odor save that of whisky and beef-tea. Saturday, Dr. K. and myself met a third surgeon in consultation. The symptoms were all carefully rehearsed, and both left doubting the existence of hernia.

Sunday morning.—As I could not get the services of either of the above, and as the symptoms persisted, I called in two others, but with no better success. The case was one of peritonitis. Death the following night.

Autopsy.—A hernia of small intestine, about two feet from the cæcal extremity. The whole retained gut lies in the inguinal canal, and does not project beyond the external ring. The testicle (now of reduced size and apparently no larger than its fellow) lies at the entrance of the canal. It can be easily separated from the bowels, but in its swollen, tender condition, with the skin and fasciæ covering it, it would have been impossible to ascertain that fact. There is present general peritonitis. The gut above the hernia is greatly distended with fluid and gas; below it, it is empty. A probe can be passed along the side of the herniated bowel into the tunica vaginalis, showing that the hernia was of the so-called congenital variety.

Remarks.—Here was a case of a man, old, feeble, reduced by diarrhœa, injured by lifting, with local pain, vomiting, and obstipation, and the evidence of a physician that a hernia had been partly reduced under ether.

As an offset to this was the testimony of a surgeon of one of our principal hospitals, who saw the case upon the second day. He says there was no evidence of hernia, nor was the testicle retracted at the time of his visit, and it was his opinion that the physician who saw the case upon the following day (a recent graduate and an interne of one of our hospitals) had either mistaken a testicle for a rupture or had injured the former in attempting to reduce an imaginary hernia. He argued that the orchitis was due to rude manipulation, and that the peritonitis was the sequel of the orchitis.

The early vomiting, nausea, and obstipation might have proceeded from the orchitis,* and the persistent vomiting from the peritonitis; and these facts, taken with an important condition,—*i.e.* the retracted swollen testicle,—and no greater enlargement in the course of the inguinal canal than would attend an inflamed spermatic cord, seemed sufficient in the minds of all I called to see the case to outweigh the possibility of a hernia.

It seems to me, reviewing coolly as I can now all the circumstances of the case, that great injustice was done the hospital physician in not deeming him competent to discriminate between a hernia and a testicle, or to think that his testimony was not of first importance when he said that he partially reduced it. His testimony, coupled with the strain, the persistent vomiting, obstipation, and local pain, should have rendered an exploratory operation imperative.

Case II.—Miss O. B., aged 43, one of three at a birth, and the first of the three to die. About two years ago noticed a tumor in the right groin that had been produced by a cough. The *lump was always present;* was troubled with obstinate constipation for the year preceding her death.

On Thursday, July 22, 1877, Dr. L. was called to see the case. At the time of his visit her abdomen was distended and she was suffering from nausea and vomiting; pulse 80; skin cool and moist, and tongue slightly furred. An examination of the groin revealed a femoral hernia, that he was assured had been present for two years. She stated that her bowels had been freely moved by cathartic medicines upon the day previous. The tumor was quite firm and hard. The patient was dull and stupid, but she did not experience any unusual symptoms.

* Curling on the Testis, p. 216.

Bismuth and pepsin, and directions in regard to diet, were all that was prescribed.

Friday.—Patient has passed a comfortable night; nausea present, but no vomiting; slight pain about the epigastrium; no movement of the bowels. The patient seems brighter and more cheerful than upon previous visit.

Sunday—Patient has been vomiting violently since Friday (Dr. L. was not notified of the change in her condition); vomited matter evidently from upper bowel, though no fecal odor; bowels confined; belly distended; pain in region of umbilicus. Pain of distention often relieved by eructations. Pulse 100, patient exhausted; pressure on abdomen does not increase but rather relieves the pain. Hernial tumor not so large or hard as on previous visit. Patient has made no allusion to the tumor as being the cause of her trouble. Patient duller than at previous visits. Could easily be aroused, and was then perfectly conscious and intelligent. A bag of pounded ice was directed to be placed over the tumor, and I was asked to see the case with him in the evening. At my visit chloroform was administered, and when the patient became relaxed and taxis used, the tumor, which was not inflamed nor imbedded among glands, became soft and gurgled. This seemed to demonstrate that the gut was not firmly grasped in the ring or canal, and as there was evidence that the hernia was an old incarcerated one, no other measures were taken than to continue the ice locally.

Monday morning.—Saw the case with Dr. L. at 10 A.M. Had passed a pleasant night; looked quite bright; had not vomited since last visit, and felt refreshed by the night's rest. No evidence of local inflammation. Tumor soft, and does not complain when it is handled. Abdomen still greatly distended; bowels confined; eructations but no vomiting; is dull, and inclines to sleep, but can easily be aroused.

Monday, 4 P.M.—There has been no vomiting since the administration of the chloroform. Patient retains her nourishment and medicine. Bowels still distended and confined. Hands cold, pulse almost imperceptible. Has failed rapidly within a few hours. Death at 9 P.M. A short time previous to her death she vomited a great quantity of fluid.

Autopsy.—An old incarcerated hernia in state of gangrene.

Remarks.—In this case there was evidence of a hernia, and a history of its presence for the past two years. Hence the question for us to decide was, *Are the symptoms those of strangulation?* There was no evidence of local inflammation. The tissues over the tumor were normal, and no inflammation of the neighboring glands was apparent. The tumor grew soft and gurgled under taxis, giving us to believe that a passage was quite as possible as during the past years of incarceration. Her dull condition, which antedated the symptoms of strangulation, was not of course due to it; neither was it due to opiates, unless taken without the knowledge of her physician. To her dull condition may be assigned the cause for not recognizing the pain of constriction or the advancing peritonitis. She only complained of an uneasy distention, and said if this were relieved she would be well.

In this case the tympanitic distention, coupled with the presence of an old hernia, should have imperatively demanded an operation. It is highly probable that the *gaseous distention*, caused primarily by alimentary difficulty, *produced the constriction by dragging upon an incarcerated bowel.* There is no evidence of primary local inflammation, and our efforts at taxis established the fact that the tumor permitted of the passage of gas. *But the hourly increasing distention of the bowel produced a correspondingly greater traction upon the entangled gut, and rendered a passage impassable that had been pervious for two years.* I am not conscious that mention has been made of this condition of tympanitis in its special bearing upon old incarcerated hernia. It is a hypothesis that seems quite probable to me, and hence I have emphasized it for the consideration of those interested in this subject.

Case III.—Mrs. R., æt. 50, had borne children; active, in good health. About six months previous to the present condition had suffered from a strangulated hernia. In this instance the hernia (right femoral) had been constricted about twenty-four hours before her family physician was summoned. Vomiting and great local pain, obstipation, with a tumor, were the symptoms that led to the belief that a hernia was present; and on appropriate manipulation the pain and vomiting disappeared, but not the tumor. This was only partially reduced, and left the physician in doubt of the restoration of the gut until the fecal passages returned. A suspicious tumor remained for at least ten days, when it disappeared.

In March, 1876, she had a similar attack. The hernia came down while she was at work. She was unable to reduce it, and was obliged to quit work and go home. This occurred on Monday evening. She was seen on Tuesday, at 2 P.M., by the same physician. Vomiting, and great suffering referred to the femoral canal, with obstipation and a tumor, led him to suspect a second strangulation. The taxis without an anæsthetic was again employed,

but not satisfactorily. The tumor was only diminished in size. Still, the pain was relieved, and, thinking that the bowel, if unreduced, would return under the use of opium suppositories, they were prescribed. At his return in the evening of the same day he found her comfortable. On Wednesday he visited her. There were no other signs of unreduced bowel than the tumor, which, it will be remembered, persisted in the first instance. On Thursday the tumor had increased in size, and I was asked to see the case. It was now three days since the physician had applied taxis. The pulse was almost normal; the skin (to the hand) seemed natural; the face looked a little anxious, but no more so than under ordinary circumstances of sickness. There were no signs of peritonitis save a somewhat tympanitic but not tender abdomen. There was a tumor in the right femoral region as large as a flattened orange, of an irregular outline, nodular as if made up of enlarged glands, and red as if said glands were undergoing inflammatory softening. The enlargement was ascribed to the involvement and inflammation of the glands, and we (a surgeon, the family physician, and myself) deemed it well to delay what we all felt would be but an exploratory operation. On the following evening (Friday, about ninety-six hours from the first seizure) an operation was decided upon. The diagnosis was correct so far as the enlarged glands were concerned. The irregular outline and local inflammation were correctly ascribed to them, but buried among them was a hernia, consisting chiefly of omentum, with a small knuckle of intestine, both in an advanced stage of gangrene.

Remarks.—In this case there was vomiting and pain for eighteen hours, *i.e.*, up to the employment of taxis (on Tuesday). From that time to my first visit, *an interval of two days*, there had been no vomiting, and the skin, pulse, and general condition of the patient were not indicative of one suffering from a strangulated bowel.

Was the physician in error in employing and continuing the use of opium, when, as he says, he was morally certain that in his efforts at taxis he had not fully returned the bowel? I think he was, although in doing so he was following a line of treatment that has been prescribed for a century. The instruction that has been found so often salutary is, "If the first efforts at taxis are unsuccessful, give a full anodyne, apply cold locally, and return, before the effect of the morphia has passed off, and make a second effort. If then the result at taxis is unsuccessful, the consideration of more effective measures is in order." The error was not in employing opium, but *in continuing* its use. The effects of a full dose of opium would have measurably passed off in twelve hours, and then the patient would have again become conscious of her condition. As it was, a grain opium suppository every second or third hour caused her to pass through the successive steps of local and general peritonitis and gangrene without exciting a suspicion of her critical condition.

Case IV.—Mrs. F., æt. 58, a widow. Dr. N., her family physician, was called to see her at 2 A.M. of Friday, November 24, 1876. The attack was similar to previous colicky seizures, and morphia was administered for its relief. Vomiting commenced about ten hours later, and persisted until evening, when the suspicions of Dr. N. were aroused, an investigation made, and hernia of the right femoral region detected. Efforts were made, under ether, to reduce it, with apparent success. On Saturday, the symptoms persisting, copious enemata were repeatedly administered. These brought away some fecal matter, and afforded temporary relief. About eight hours after the last enema the patient passed quite a copious liquid stool, with considerable flatus, and felt immediate and almost complete relief. Sunday morning the symptoms of obstruction were unmistakable, and I was sent for. I did not see the case until 5 P.M. Operated; bowel livid and rapidly approaching gangrene.

Hardly had she recovered from the effects of the anæsthetic when she was seized with excruciating pain about the heart and between the shoulders, and vomited as before. A hypodermic gave her complete relief. About midnight she had a slight movement of the bowels, and expressed herself as without an unpleasant symptom.

Pain about the heart returned on the following day, and she expired eighteen hours after the operation.

Remarks.—In this case the unusual feature is that although the enemata seem to have been returned almost immediately after they were administered, and that too without much relief, an apparently natural evacuation, accompanied with flatus and almost complete relief, occurred about eight hours after the last one had been administered. Nothing can in this case be laid to the treatment, as the attending physician had recommended an operation upon the day following the strangulation. It was not until after it was too late that consent was given.

It is further worthy of note that there was no previous history of hernia, and no unusual straining to provoke one. It

seems to have attracted her attention first at midnight. If so, this is the second case I have known in which the patient was aroused from sleep with strangulated hernia, having retired without any unusual symptoms.

The *diagnosis* of intestinal obstruction is one of the obscurest and often one of the most unsatisfactory that the surgeon is called upon to make. Dr. Hunt, of the Pennsylvania Hospital, says of hernia, "I have seen the best and worst of surgery connected with it;" and George Pollock says, "The causes of intestinal obstruction are so various, its occurrence is fraught with so much danger, its symptoms are so severe and distressing, its diagnosis is so obscure, and its treatment is so uncertain and so often unsuccessful," that he enters upon the subject with extreme reluctance.

In a recent treatise on surgery, the author gives the following diagnostic symptoms of strangulated hernia—I have placed his words in italics. He says, "*Strangulation is marked by total and usually sudden constipation.*" This is true, and is always possible, in point of fact; but in Case II. the bowels had been freely opened by cathartic medicines *the day before* she sent for her physician, and hence the fact of no movement of the bowels that day, or for two or three days, is not significant. Habitual constipation is so frequent, and persons insensible to unusual amounts of cathartic medicines are so numerous, that this symptom is of only secondary value. One of my patients says that she habitually goes three weeks without a movement of the bowels. This is unusual, as she is of active habit. Another, an old man, confined to his bed, goes an equal time.

In Case No. IV. the patient had quite a natural movement, with flatus and subsidence of pain. Of course this was from the bowel below the constriction, but is worthy of note, lest it mislead in a similar case.

"*Urgent vomiting, at first merely of food, then of bile-stained matter, next of the contents of the small intestines, and finally of fæces.*"

In Case No. III. there was no vomiting from Tuesday until Friday night, though the gut was constricted and gangrenous at the time of operation. The opium given might have controlled the vomiting, yet there was not enough administered to give a bystander the impression that she was under its influence.

The early setting in of vomiting, and its urgency, will, I think, depend upon the tightness of the constriction, and the character of the vomiting will depend upon the region of the bowel that is constricted.

In Case No. I. the vomiting was continuous for five days, but at no time of a suspicious odor, neither is it possible to have the suspicious odor with "fæces," unless the constriction is below the fecal-forming function of the intestine. In only one of the four cases was there fecal vomiting. Besides, fecal vomiting may be present in peritonitis, and thus this symptom of vomiting, *and even fecal vomiting*, a symptom that is associated with manifold diseases, contributes nothing positive to the diagnosis.

"*There is great distress and pain, usually in the tumor, and almost always in the neighborhood of the umbilicus, frequent irritable pulse, dry and brown tongue, tympanitis, and often considerable tenderness of the abdomen and distress of countenance.*"

With the exception of the allusion to the pain in the tumor, all the above symptoms are true of incipient peritonitis, and hence if there is no tumor present, as in Case I., the diagnosis of strangulated hernia is not clear.

His remaining points in the diagnosis relate to the advanced stage of the constriction, and these resemble the inflammatory stage of peritonitis and the typhoid condition of gangrene.

It is to the *early*, not the *remote*, symptoms in all cases of strangulation that one must look for reliable data. The instant general peritonitis sets in, the greater masks the lesser local pain, and the tympanitic distress renders the patient often oblivious to active inflammatory changes. The history of the first twenty-four hours has therefore a far greater value than subsequent revelations, and these hours should be most carefully and critically interrogated and their information constantly kept in mind.

The symptom of tympanitis, which is always decidedly pronounced in intestinal obstruction, is valuable, but it does not enable us to determine positively that the obstruction is due to hernia.

As careful as are the authors in their descriptions and diagnostic features of this distressing disease, it yet remains to point out symptoms that will warrant surgical

interference in cases where there is *no tumor* present. *There are no infallible symptoms*, and, though the strongest assurance may rest in the mind of the attending physician of the true condition of the case, still he can only say, "I think such is the case."

What then is to be done? Is the case to be abandoned? We certainly do abandon it when we take no measures to determine positively the suspected injury. With vomiting or nausea, with local pain, with obstipation and distended abdomen, especially when these symptoms appear suddenly, we have good reasons for suspecting a strangulated bowel; and if these symptoms remain unexplained for twenty-four hours an exploratory operation is not merely justifiable, but it is demanded. In Case No. I. such a procedure would have enabled me to map out the relation of the testicle and cord to the canal, and to have detected the gut, that was confined wholly within it. No harm would have been done the inflamed testicle; on the contrary, the depletion and removal of the tense overlying structures would have been salutary. In Case No. III. the operation was finally undertaken in the midst of doubt, and our gratification at finding the diagnosis a lucky one was more than counterbalanced by the chagrin of seeing the bowel in a state of gangrene.

If an exploratory operation were a grave affair or would diminish the chances of recovery, it would not be suggested in this place. But such is not the case. Let the hidden nature of the disease be what it may, the cutting through the skin and overlying fascia cannot prove a serious complication. Such a course is hardly more than opening a bubo.

I am well aware that such a course would meet with much opposition, but the inevitable consequences of strangulation, the fearful death that may be averted, the satisfaction of having done one's full duty, is a great reward, and far outweighs the unjust and vicious criticism that is sure to follow from the envious and ignorant in case of faulty diagnosis.

PHILADELPHIA, 1328 SPRUCE STREET, May, 1877.

DR. FREDERICK T. ROBERTS and Dr. W. R. Gowers have been appointed Assistant Professors of Clinical Medicine by the Council of University College, London.

REMARKS ON A COMPARISON OF THE WEATHER REPORTS WITH THE CATARRHAL DISEASES OF CHILDREN, ETC.

From a paper read before the Philadelphia Obstetrical Society

BY JOHN M. KEATING, M.D.,

Physician to the Philadelphia Hospital, Assistant Physician to the Children's Hospital, etc.

IN attempting to establish a new system for the comparison of disease with that element of its causation dependent upon weather changes, I but carry out an idea suggested by the vast accumulation of case-reports in our city dispensaries, which have hitherto been useless and cumbersome.

That the mortality statistics are by no means the correct exponents of the extent of disease is obvious, partly on account of epidemic influences, which intensify or diminish the malignity of the epidemic, and partly on account of the comparatively low mortality which usually attends disease of the catarrhal kind. The utter unreliability of the diagnosis must be also taken into consideration. The idea, originating, I believe, with the Massachusetts Board of Health, of issuing to the profession headings of the different ordinary acute diseases, with a request to fill up with the required data, was excellent in theory, but has not brought in the full statistics that were desired.

I have thought that a more accurate way of accomplishing this end was to tabulate from the dispensary books. In our large cities thousands attend these institutions yearly,—chronic cases in adults and acute in children. To those who are interested in this department of medical research I would suggest the establishment of a regular monthly report from all our dispensaries and hospitals, simply giving the age, sex, condition of life, diagnosis, and, what is particularly desirable, the date of attack as accurately as it can be determined. These reports compared with those of the Signal Service will surely make most valuable material for the advancement of hygiene and prophylactic medicine.

During the months of July, August, September, and October, of 1876, I had an opportunity of noting myself the cases coming for advice to the dispensary of the Children's Hospital, and, with some other records furnished by my colleagues of the staff, I have prepared a chart, in the hope that the subject will appear sufficiently interest-

ing to attract attention. The children for the most part were under seven years of age. They were brought from all parts of the city, and belong to that class whose position in life subjected them to vicissitudes of temperature without the necessary means of protection; in fact made them living thermometers and barometers. It may be remembered that in the early summer the average heat was so intense and the humidity so low that the mortality among children was greater than for many previous years. During the four months I selected all the cases of cholera infantum and entero-colitis, and classified them under the head *Diarrhœa*; the catarrhal, laryngeal, and bronchial affections, including a few cases of pneumonia, were classed as *Bronchitis*.

The great difficulty arising at the outset of such a series of observations comes from the utter impossibility in many cases to date the exact period of attack, the parents counting back to events (as the funerals of friends, and such like), and not to days, when questioned. I have found that for the intestinal cases an average of four days from the date of admittance will reach pretty closely the date required. I have therefore allotted to each day the number of cases which occurred on that day, and compared them with the diagram representing the report obtained from the United States Signal Service for the same day.

The bronchitis line from the Children's Hospital comprises three hundred and sixteen cases. Of these one hundred and fifty-one were boys, and the remainder (one hundred and seventy-five) were girls.

From the dispensary at the Episcopal Hospital, the report of which was sent me by Dr. Robert M. Smith, I have additional data. During the four months one hundred and seventy-seven cases in children applied. Of these, thirty-five appeared in July; thirty-two in August; forty-eight in September; sixty-two in October. Bronchitis seems to have been prevalent during all the months, but the number of cases gradually increased, reaching its maximum in October. This fact is also borne out to some extent by the city mortality list, with the exception that this affection seemed more fatal, proportionately, in early summer than in the fall.

From the Children's Hospital I note two hundred and thirty-six cases of diarrhœa. Of these, one hundred and thirty-three were girls, one hundred and three boys. At the Episcopal Hospital there were one hundred and fifty-eight cases,—sixty-eight in July, fifty-seven in August, twenty in September, thirteen in October. The city mortality coincides to some extent with this, with the exception that a far greater mortality is noted for July.

Comparing these data with the weather reports of the Signal Service, I find that a persistent high temperature, with comparatively slight difference in the maximum and minimum table, with low average humidity,—in other words, persistent dry hot weather,—will coincide with the report of the diarrhœa cases; and when these conditions subside, the number of cases will also diminish, and the number of deaths will disproportionately decrease. On the other hand, as the mean temperature reaches its lowest point, and the greatest difference exists between the highest and the lowest daily record of the thermometer, the number of bronchitis cases reaches its maximum. Changeable weather in point of temperature alone seems to favor the increase of pulmonary catarrh. My observations scarcely cover sufficient time to draw from them any definite conclusions. If more extensive records hereafter bear out the remarkable coincidences which these observations show, they will prove the importance of more perfect hygienic measures for the prevention of those diseases which result in the frightful mortality among children during the summer months.

Here arises the question of treatment of the diarrhœa, which is the most important. Unquestionably, if these statements are correct, medicinal treatment will yield comparatively poor results. Our main reliance would be change of air, and more temperate atmospheric surroundings. But where such cannot be attained, certainly our endeavor should be to exclude the obnoxious influences as far as is possible.

We all know what wonderful changes are brought about by taking children to the sea-shore in an almost moribund state, where medicine and change of diet have been ineffectual.

In presenting this résumé of cases I cannot but feel assured that all who glance at it will think with me that, in the aggregate, treatment has been of little avail. Individual cases may have recovered, and

credit given to the medicines used, but certainly the general average of deaths has been the same, the mortality curve on the chart bearing a definite proportion to the number of cases presenting themselves. Seeing how utterly useless medicinal treatment was in many cases, I was led to adopt an altogether different method, and the success which attended its use, in those cases where my instructions were thoroughly carried out, warrants me to call upon the profession to test its full value during the coming campaign, and report for or against it.

In the first place, I abandon in the first stage of the attack the *absolute* milk diet, particularly mother's milk, and rely instead on a weak preparation of condensed milk, diluted to suit the age of the child, containing, as may be required, either lime-water or (preferably) salicylic acid or malt, and upon fresh meat juice. The juice should be extracted from fresh meat, and given in tablespoonful doses twice or three times a day, according to the age of the child. The child should be lightly clothed. Every night and morning I require the child to be rubbed from head to foot with cod-liver oil. The more advanced the case,—that is, the more choleraic the stools,—the more essential does this rubbing become, in the armpits, on the belly, in the groins, until the surface is thoroughly greased, and then the child is wrapped in an old, thin flannel blanket, and allowed to enjoy its greasy bath for about an hour. The surplus oil is then rubbed off and the child dressed. Washing is to be done each morning after waking, and before the oil rub is given.

I have seen, in the short experience of four years, the most remarkable results follow this treatment when it has been conscientiously carried out. The treatment is a most rational one. We have seen that the summer complaints of children depend entirely upon high temperature (excluding, of course, those few where indigestion from green fruit is the cause), and consequently anything that will depress the temperature or exclude its pernicious influence will be curative or preventive. Olive oil was used by the ancients for anointing, but it seems more reasonable to use an animal oil, which is nutritive at the same time, and consequently serves two purposes. We know that oily matter is but slightly changed in its preparation for assimilation, that its accumulation throughout the body acts as a protection, and our main endeavor should be to add to the supply as often as the increase of the danger against which it guards demands its presence. The odor of cod oil has been objected to, and it is certainly a most serious objection. To remedy this, Messrs. McKelway & Borell, of this city, have succeeded in making a deodorized preparation, which seems to serve the purpose admirably.

I do not wish it understood, however, that I am entirely opposed to the use of medicines. The occasional use of acid, or at other times of alkalies, corrects the character of the passages, and often regulates them, and in mild cases they will be found amply sufficient. But I must confess that it seems useless to attempt to treat the effects when the cause is allowed to continue, to give astringents and opiates to check a catarrh when high temperature or sudden changes are allowed to exert their evil influences.

I feel confident that the most useful and important work to result from the reports of the Signal Service will be to warn us of sudden changes, for our self-protection, and guard us against extremes which to some are fatal.

A CASE OF POISONING FROM OIL OF TANSY; RECOVERY.

BY A. E. SPAULDING, M.D.,

Winnebago, Ill.

ON Friday, May 12, at 12 o'clock M., I was summoned in haste to see Mrs. F., æt. 21, who, it was stated, was "having a fit." I found her lying on the floor, conscious, and vomiting. While inquiring of those present the character of the convulsion, the patient uttered a loud scream, powerful tonic contraction of the flexor muscles came on, the forearms were drawn forcibly against the thorax, face deeply congested and livid, foamy saliva was ejected from the mouth, eyes were wide open, and remained so during the convulsion, which lasted from one to two minutes. When the convulsion ceased, the patient vomited, the contents of the stomach emitting a peculiar odor. Upon inquiry, I learned from the husband that she had taken a teaspoonful of oil of tansy at nine o'clock A M., for the purpose of bringing on her menses. I immediately administered an emetic of sulph. copper, which produced free vomiting. The patient complained of headache, but had no more

convulsions. I have thought this case deserving of report on account of the extent to which tansy is used as a household remedy in suppressed menstruation, and that the physician may be aware of the symptoms produced by an overdose. A fatal case of poisoning from one drachm of oil of tansy is recorded in the *American Journal of the Medical Sciences*, xvi. 256, death being preceded by coma and violent convulsions.

TRANSLATIONS.

Gastrotomy. — M. Lannelogue (*Bull. Gén. de Thérap.*, 1877, p. 370) reports the following case. A man 59 years of age, who had previously enjoyed good health, was suddenly attacked with pain on deglutition, which grew progressively worse until at the end of six months only a few spoonfuls of milk could be swallowed. About the middle of the thoracic portion of the œsophagus a very resistant and immovable object could be perceived: emaciation was extreme, but there was no cachectic tint. All the other organs were healthy. In order to prevent the death of the patient from inanition, gastrotomy by Verneuil's operation was performed (Acad. de Méd., Oct. 31, 1876). The operation was not followed by any unfavorable symptoms,—no pains, no inflammation. Alimentation was carried on by means of the fistula, which, however, allowed a notable quantity of liquid to escape. Subsequently thoracic complications occurred, which carried off the patient the twenty-sixth day after the operation. The autopsy showed primary lesion (epithelioma) of the œsophagus, which, having suppurated and burst into one of the bronchial tubes, brought about death by asphyxia. The stomach, however, remained solidly adherent to the abdominal wall, the gastric fistula being well formed, and the operation completely successful. M. Lannelogue draws the following conclusions: 1. Gastrotomy is a rational operation, based on the results of experiments upon animals and men. 2. It is always indicated when death by inanition is threatened as a result of aphagia. 3. Verneuil's procedures should be followed closely, the stomach not being opened until it has been firmly attached to the abdominal walls by numerous fine sutures, so as to avoid leakage into the peritoneal cavity. Some modifications in point of detail should be practised: these consist—4. In not passing below the inferior border of the eighth costal cartilage in the incision of the integuments, so as to reach more directly the anterior walls of the stomach, which in these patients is always shrivelled and retracted towards the diaphragm on account of long abstinence. 5. In opening the anterior wall of the stomach in the neighborhood of the lesser curvature, so that the various liquids secreted or injected shall always have sufficient room to accumulate without running out. 6. Not to apply either hæmostatic pincers or fastening threads for the cannula to the borders of the wound, for fear of tearing or mortification, which would enlarge the fistula and render the escape of fluids easier. x.

Solubility of Quinine Salts.—At a recent sitting of the *Société de Médecine Pratique* (*La France Méd.*, 1877, p. 358), M. Yvon stated the results of his experiments upon the salts of quinine. Those used at present for hypodermic injection are somewhat insoluble, and require the addition of acid, which irritates the tissues locally and renders their absorption less easy. The sulphate of quinine dissolved in acidulated water and the bromhydrate of quinine are no exceptions. Lactate of quinine is less objectionable in this respect, being soluble in nine parts of water. The solubility of bromhydrate of quinine is but little less than that of the lactate, it is true, but the latter contains less acid, which is advantageous as regards its therapeutic action. M. Yvon has also made investigations regarding the elimination of quinine by the kidneys: this is always considerable, and, as M. Guyochin has shown, is in the form of quinoidine. x.

Bilateral Lithotomy with the Extraction of Thirty-two Calculi.—M. Alfaro reports (*Anales de la Asociacion Larrey*, Mexico, ii. 12, 185) a case of bilateral lithotomy, after the method of Dupuytren, in a man aged 67 years, who had in addition to the vesical trouble three herniæ,—two inguinal and an umbilical,—and hemorrhoids. The operation presented no difficulty, and there were extracted, without any trouble, thirty-two calculi composed of uric acid, urate of lime, etc., which weighed altogether a little over one ounce when dry. By the twentieth day the wound had healed entirely, and the patient passed urine by the meatus without difficulty. J. B. R.

PHILADELPHIA
MEDICAL TIMES.

PHILADELPHIA, JULY 7, 1877.

EDITORIAL.

HOMŒOPATHY.

WHILST, under the shadow of the Upas-tree of imperfect education, homœopathy flourishes in this country, in England and upon the continent of Europe it is being strangled by the growth of knowledge within and without the profession. A very noteworthy evidence of this is furnished by a letter recently published in the London *Lancet*, which, from its importance, we republish here almost in full. The circumstances under which this epistle was written are as follows. Dr. Wyld is vice-president of the Homœopathic Association of Great Britain, and in a semi-official manner called on Dr. B. W. Richardson, in order if possible to bring about a reconciliation between the two "schools" of medicine. Dr. Richardson asked him to put the statements he made into writing, and a few days later received a letter from him. The first portion of the letter recounts the expulsion of the homœopaths by the British Medical Association. We omit this, but give the remainder verbatim:

"Since 1851, however, great changes have taken place in this country on both sides of the medical question. Many men have arisen in the ranks of medicine who have renounced all the heroics of the past in the treatment of acute disease, while the so-called homœopathists have, on their side, almost entirely abandoned the use of globules, and have substituted doses in a tangible form, their rule for the dose being, in effect, to give a dose sufficiently large to effect its purpose, but not so large as to discomfort or weaken the patient. Further, we find that, whereas the early homœopathists denounced all auxiliaries in the treatment of disease, it is now the practice to make frequent use of all remedies of a simple kind, such as occasional aperients, anodynes, opiates, anæsthetics, tonics, galvanism, hydropathy, Turkish baths, and mineral waters. In short, we define our practice as rational medicine, including the application of the law of contraries, but *plus* the application of the law of similars.

"Beyond all question the abandonment of heroics on the one side, and the adoption of tangible remedies on the other side, has, to common observation, brought the two schools into a very close juxtaposition, and the question, therefore, presents itself, 'Can that ostracism which might by some be considered justifiable in 1851 hold good with any justice under the altered circumstances which now exist?'

"To this question you may reply, 'We do not ostracize you because you prescribe medicines according to a specific rule, nor because you prescribe them in an unusual form, but we deny you professional intercourse because you proclaim yourselves sectarians, and by means of books, journals, societies, and hospitals, advertise yourselves homœopathists.'

"To this we answer, that we do not desire so to publish ourselves; we do not write homœopathists on our door-plates; many of our best books eliminate the name homœopathy from the title-page; and, as a recent example, a large number of our body have objected, in a memorial, to the title '*Homœopathic* School.'

"We say, admit us on equal terms to your medical societies and to the pages of your journals, and all sectarianism will begin from that day to decline, and this, I believe, will ultimately lead to the abandonment of all sectarian societies, journals, and hospitals. In a word, we demand the same liberty of opinion in medicine as in religion or politics, and an amalgamation with the great body of the profession on equal terms. If this were granted, we can see solid advantages to the profession on all sides, an increase in the amenities and dignity of medical life, and a higher professional status for all in the estimation of the public.

"To recapitulate. We admit, First, that the views expressed by Hahnemann are often extravagant and incorrect. Secondly, that Hippocrates was right when he said, 'Some diseases are best treated by similars, and some

by contraries,' and therefore it is unwise and incorrect to assume the title homœopathist. Thirdly, that although many believe that the action of the infinitesimal in nature can be demonstrated, its use in medicine is practically, by a large number in this country, all but abandoned.

"On these grounds, and maintaining that we are legally qualified medical men and gentlemen, we claim the right of admission to your medical societies and to professional intercourse with the entire medical body.

"In conclusion, I must beg to remark that, although this letter must be regarded as non-official, the sentiments it expresses are, I believe, held by a large number of our body.

"Believe me, yours sincerely,

"GEORGE WYLD, M.D."

This letter has drawn out an angry rejoinder from the president of the Homœopathic Association. It would seem, therefore, that Dr. Wyld's frankness is not relished by all of his colleagues. It is further stated that the Association is divided into two increasingly hostile factions, the one desirous of professing, if not of actually practising, Hahnemannism, the other intent upon honesty of profession. It would seem inevitable that as the years go by the breach should widen until the parties could not coexist. The regular profession in Great Britain is no doubt willing to grant liberty of opinions to the fullest extent. In this country the code says nothing about homœopathy, but forbids consultation with those who hold an exclusive dogma; and any person who would publish or subscribe to the doctrines enunciated by Dr. Wyld would certainly not come within the pale of the taboo. No regular medical association could, compatibly with its own dignity, receive any coequal association of medical men in a body; but the British Medical Association or any of our organic societies might very well receive a man who would subscribe to the above letter, whatever the past record of such an individual upon the homœopathic question might be. The true position of our societies is to be found in the assertion, We are not exclusive, but you who subscribe to an exclusive dogma are so, and whenever you will abandon this exclusiveness we will receive you by individual election, precisely as all of our own members have been received,—one by one.

THERE is one point in the above letter we want to call attention to, because it substantiates the one unanswerable refutation of homœopathy, and because the text shows how little the force of this refutation is known or understood. It seems to us that all other reasoning upon the subject should be abandoned, and this one line of argument steadfastly kept before the profession and the public.

A law of nature is absolute, unchanging and unchangeable, always operative, always tending to produce the one effect. Thus, the earth always draws towards itself: if it was found that sometimes it drew towards itself, sometimes repelled, it would be proven that the law of gravitation does not exist, but that the attraction and the repulsion have their origin in some other law, electrical or otherwise. Now, in the letter we read of the law of similars and the law of dissimilars. This is an impossible thing in the economy of nature. We repeat, two absolutely antagonistic or opposite laws cannot exist, and when it is asserted that laws of this character do exist such laws must be apparent, and not real: behind them there must be some law which is supreme, invariable, and which, in its action, may give seeming but not real contradiction.

The cause of the difficulty and of the apparent paradox in the case under consideration is that pathological conditions and symptoms have been confounded as one, whereas they are entirely different. Thus, diarrhœa may depend upon excessive irritation of the bowels; then a sedative like opium is given, and the law of dissimilars apparently operates; or diarrhœa may

depend upon relaxation; then a stimulant like veratrum album may in small doses cure, although in large doses it purges violently by irritation; here the law of similars apparently asserts itself. Putting the same thing in another form, excessive irritation may produce diarrhœa, opium stops the flow under the so-called law of similars, but excessive irritation may produce constipation, and opium increases the flow apparently in obedience to the law of dissimilars. It seems to us as plain as black is black, that these and innumerable other examples which might be adduced show that it is not the symptom but the condition which must be treated, and that the so-called laws of similars and dissimilars are not laws of nature, but fictions of the imagination, bred of ignorance and maintained by prejudice and fraud.

CORRESPONDENCE.

LONDON LETTER.

THE season for societies has now closed, and the profession is engaged in pushing practice during the remainder of one of the dullest social seasons ever known. In addition to the general depression, the weather has been dark and sunless, or at other times sunny with a trying east wind, which was very objectionable to the gouty, the rheumatic, and those subject to bronchitis. If the season had been as late in the year when Charles II. hid himself after his defeat by Cromwell at Worcester as it is this year, the foliage of that famous oak-tree would scarcely have effectually concealed him; and there is no telling how such a fact might have led to very important issues. This weather has had little effect upon the progress of smallpox, for there are at present in the Metropolitan Asylum District Hospitals no less than 964 patients, so that the gentleman whom I mentioned in my last letter as bewailing its decline, as interfering with his therapeutic projects, was a little premature in his sorrowing. A powerful letter from the acting editor of the *Lancet*—in his private name, however—appeared in the *Daily News* a day or two ago, in which he showed that British legislators were anxious about the welfare of cattle, but could spare no time from their pursuit of party to consider the presence in our midst of a preventable disease which was slaying some seventy-five per week and disfiguring hundreds of others. The attention to sanitary matters which the present government so loudly vaunted when striving to come into power has not been given: indeed, no pretence has been made of attempting to keep their promises in this respect. The unfair way in which the Anti-Vivisection Act is being worked by them was brought before the General Medical Council by a letter from one of the secretaries of the new Physiological Society. No less than nine well-known physiologists having complied with the provisions of the act and sent up proper certificates, etc., found themselves either in the position of being simply refused their licenses or having them so delayed as to seriously interfere with their object. Had they been nine publicans who had been treated thus, the Commons House of Westminster before now would have rung with indignant speeches from several of its beer-born members. But matters of health and sanitation are said to be purely medical matters, and thus disease is left to be fought by those whose livelihood depends upon its presence, while those who furnish the patients seem to think it is no business of theirs. Such being the case, it is no matter for surprise that the progress of sanitary science is as slow as it is: it redounds to the credit of the profession that any progress is made at all.

The advantages of hospitals for the poor are so widely recognized that an attempt has been set upon foot to provide several hospitals if possible, and one at least, for the reception of middle-class patients who could pay so much a week for their residence there, out of which the medical officers could receive some remuneration.

London houses are not arranged with all care to the possibility of sickness; they are filled and worked on the supposition that every inmate will remain not only well, but filled with energy. It is only in the mansions of the wealthy that suitable rooms and sufficient attendance for sick persons are attainable at all. Even in good streets a room capable of being converted into a sick-room, with a sufficiency of ventilation, etc., is scarcely ever contemplated; and in the great majority of instances such an idea never floats across the mental horizon of the inmates even temporarily. The matter of suitable accommodation for middle-class persons is at last brought before the notice of the public, and a meeting was held the other day under the presidency of the Lord Mayor to consider the subject. It is no longer thought sufficient to provide sick persons with drugs, and to trust them to the affectionate solicitude of friends, well meaning, but commonly utterly ignorant of nursing, and consequently often doing as much mischief as good; or, as often happens, to such attention as may be furnished by overworked domestics, afraid of all sorts of potential dangers: it is held that skilled nursing is essential. Now, of course,

there is no space in ordinary houses for a nurse, and even a trained nurse cannot watch night and day forever, but must have her hours of rest, so that the need for such hospitals is urgent enough, and the matter important enough to warrant attention being given to it. Probably the need exists elsewhere as well as in London, and is not confined to this continent. Considering how trying the modern race for wealth and position is, and the increased risk of sickness engendered thereby, the question is one which comes home to all, enterprising young men especially, as well members of our profession as others. Even to the healthiest and strongest the question often makes itself prominent, "What should I do if overtaken by illness?" And what would have to be done in many cases is not pleasant matter for thought, nor a cheerful subject for contemplation. The poor inmate of a general hospital then becomes an object of envy, and the careful attention of a skilled nurse, together with the conveniences of a sick-room, are sighed for by those who feel that at present no such arrangements are feasible in their case.

On Saturday, May 26, a distinguished assemblage met in the gardens of Prince's Street, Edinburgh, to witness the unveiling of a bronze statue of the late Sir James Young Simpson, Professor of Midwifery in the University of Edinburgh. Lady Galloway unveiled the statue. Dr. Wood, an old and cherished friend of the late professor, made the presentation on behalf of the Committee of Subscribers, a task which was to have been performed by the late Earl of Dalhousie had he been still alive to do it. With conscious pride in his profession at large and his late friend in particular, Dr. Wood pointed with an intelligible satisfaction to this public recognition of the worth of the deceased baronet. Almost under the shadow of the mighty memorial raised to Scotland's greatest author, Scott, alongside the statues of the well-known Christopher North and of Allan Ramsay, the poetical barber, whose pastorals have made the glens round Edinburgh of world-wide fame, now stands a monument of one who held an honored place in the heart of every person of Scottish birth. Sir James Simpson was a national favorite, and the most personally popular man in Scotland of his day. As Dr. Wood said, "It will show to all the rising generation how an obscure tradesman, with neither station nor money, by the talents with which God had endowed him, and an energy and perseverance without which genius so often fails, could climb to a very high position, and live honored and die lamented."

Hard-headed as the Scotch are, they possess, well hidden away, a lump of solid sentiment; and every Scotchman feels a thrill of pride in the ambitious baker's boy who climbed to be a university professor and a baronet, and in the national educational arrangements which made such a progress feasible. He tells with proud satisfaction how the tradesman's boy worked his way, how he took short-hand reports at nights in order to scrape together the fees requisite for his college course. The fight betwixt young Simpson, at nine-and-twenty, and a well-known Dublin professor is still fresh in their memory; and the town council of Edinburgh know well that their selection of their townsman on that occasion to the vacant chair of midwifery has always been held to be a set-off against a lot of blundering and no little iniquity. And yet it was by an accident that Simpson was reserved for his distinguished career. When he had passed his final examination and become a medical man, straitened means compelled him to look about at once for some method of maintaining himself, and he tried unsuccessfully for a small parochial appointment on the banks of the Clyde. Disappointed, he returned to Edinburgh; and how keen his disappointment was may be estimated by the fact that in his later years, on a public occasion, he declared that this failure gave him a keener sense of chagrin than anything that ever occurred to him after. In this forlorn state he was enabled by the sympathy of a professor to maintain an existence in the university, where his abilities soon earned for him a place amidst the worthies of his native land. The most distinguished persons were his patients, and his name was familiar to the medical students in every country. And now, a few years after he has passed away, his admirers have subscribed more than £5000 to keep his memory fresh and to place a memorial of him alongside the great ones of their country. The Lord Provost, in accepting the gift, pointed to the statue of another pioneer, of a different kind, but of whom Scotland is equally proud, the enthusiastic and high-souled cotton-spinner, who minded his loom with his book before him; and also to that of another medical man,—Dr. Livingstone, the African explorer. There they stand, an honor alike to their country and their profession, to cheer on many another Scotch laddie to do all that lies in his power and to make the best use of the talents with which he is endowed.

The question of the responsibility of epileptics for acts of violence, often homicidal, perpetrated by them under circumstances which almost preclude malice aforehand, has recently been the subject of much comment. A few months ago, a comparative youth deliberately shot an old man with whom he had just dined. There was no ground of malice prepense, except the possession of a revolver by a person who apparently could have no necessity for carrying such a weapon about with him. The jury took the view that the possession of this weapon, and especially its recent purchase by a man who had no necessity for it and no superfluous money to spend, was significant of a design against somebody

or other, and returned a verdict of wilful murder. Consequently the youth was to be hanged. Looked at from a purely economical point of view, this was undoubtedly the cheapest way of getting rid of a creature useless, or nearly so, in itself, and of no value as a proletaire; but a number of people strongly dissented from this view, and had influence enough to get the youth examined by the president of the Royal College of Physicians and the Lord Chancellor's Visitor in Lunacy. The result of this was that the youth was reprieved and sent away to a criminal lunatic asylum during her majesty's pleasure, which means for the term of his natural existence. A storm of controversy arose therefrom. I have excellent reasons for stating that the real cause of the reprieve was not connected with the question of responsibility or irresponsibility, but consisted in the fact that as this youth had always been attacked with epilepsy when much excited, as during his trial, and at other times, it was morally certain that he would be similarly attacked when the time for hanging him arrived, and that he would in all probability be legally strangled in the unconscious condition of an epileptic convulsion or paroxysm. This might be a merciful state of affairs for him, but would have excited much comment, especially by the strong party who are opposed to capital punishment, headed by the *Examiner*,—not the *Medical Examiner*. So the lad was reprieved, and, as the real cause had not leaked out, there was a great newspaper controversy about the responsibility of epileptics.

A most elaborate article on the subject appeared in the *British Medical Journal*, unsigned, but bearing self-evidence of being the work of Hughlings Jackson. The view taken up was this: that it is well known to all alienist physicians that epileptic patients are often furiously maniacal after their paroxysms; and, according to most authorities, epileptics sometimes become suddenly maniacal, instead of having an ordinary epileptic paroxysm. During the discharge of epilepsy there is unconsciousness, with or without convulsion. After the fit there is a state of mind left which is more or less automatic. In popular phrase, he is not quite himself,—a perfectly accurate phrase. There is apparently a state of temporary exhaustion of the higher centres, which leaves the lower ones in a condition of imperfect control; in other words, the patient for the time being is in a much more automatic condition than is the normal state. The depth of this reduction may vary from the status epilepticus, or complete prostration which follows an epileptic hurricane, or storm after storm, up to a condition of high mental automatism closely approaching normal consciousness. The less deep this exhaustion, the higher the centres left uncontrolled or over-active. Thus, after a slight petit-mal a condition of very high automatism is left, and acts closely approaching those of full consciousness are performed. Thus, instead of a vague mass of fury there is a state where the acts are associated with the surroundings. Thus, this writer states, exceedingly elaborate actions may be done by epileptics when unconscious after their fits.

Two instances of such a state of high automatism are given from the experience of an epileptic, himself a medical man. At times he has severe epileptic attacks, while at other times he has but slight, transitory seizures. One day, when going with his wife to see a cathedral, he had a slight seizure. In the close, at the time, he had the impression of the building before him, and in the post-epileptic state formed the idea of the building being Buckingham Palace; and he asked his wife if they should not inquire for the housekeeper. The attack of petit-mal was so slight that his wife observed nothing wrong, and she thought he intended some joke. On another occasion a much more serious error was very nearly committed. During attendance upon a case of midwifery a slight attack came on, and in the post-epileptic state he had the impression that he was with a woman of the town, and he narrowly escaped an act which would have involved him in fearful odium, and professionally ruined him, even if nothing worse had happened to him. Thus, there is after each epileptic fit a state of "dissolution," using the term as the opposite of "evolution," this state varying in depth according to the severity of the fit. The slighter and more transitory the fit, the more easily is it overlooked, and the more elaborate, the more nearly normal are the actions and the more they seem purposive to on-lookers. This is a subject which calls for close attention on the part of the profession, and the after-actions of epileptics should be carefully noted by those who have the opportunity of observing them.

The interest felt in the election of a successor to Sir William Fergusson in the chair of Clinical Surgery at King's College has been well maintained, and many and various were the rumors. The reply made by Professor Lister at Edinburgh, to a memorial signed by some seven hundred students, was held to indicate that he had no intention of "coming South," and that London held nothing good enough to tempt him from the Northern capital. But, as events show, such an interpretation was unfounded, for Lister is now Professor of Clinical Surgery in King's College. Whether such change is not rather a come-down in the world, is a matter on which opinions may vary; but it is certain that the council of King's College exercised a worldly-wise intelligence in securing one so well known as Professor Lister. Many students will be attracted by the great exponent of the antiseptic system, and will take out his course at least, and this will prop up to some extent

a school which has been withering, partly from its government and partly from its association with the Church of England,—an association which has had a baneful influence. A profession of faith is required from its teachers and professors, and chapel attendance was once anyhow a necessary matter with the students, however this discipline may be relaxed now. King's College was founded as an opponent of University College, which was then represented as being decidedly materialistic, and was to be the stronghold of orthodox science; but somehow its religious connections have been disastrous to it. It has had to drop practically the religious test with its professors, and the school wanes, and will not recover till chapel attendance, and all that is linked with it, is abolished.

Students will undoubtedly be attracted by Professor Lister's well-won fame, and to many his coming to London will be very satisfactory, as they will so be enabled to see his method as applied by himself, instead of having to spend a session in Edinburgh in order to attain that end. But Professor Lister, though now near the great highway of the earth, and thus brought within reach of many American and Continental visitors who could not have seen him in Edinburgh, will not have it all his own way in London. He is not a brilliant operator, and as to his method and his results he will find himself the object of keen critical attention. A man may be very prominent in the provinces, but London medical societies bring a man to his level very quickly, and it remains to be seen how far Lister will bear the tests to which he will be subjected. If he really has the capacity to ride on the crest of the wave of opinion here, then he establishes the fact that he is a surgical genius; but if he fail to attain this, it may be a matter for doubt how far he has consulted his best interests and his reputation by his southward migration. Mr. Smith has been elected to the chair of Systematic Surgery, an honor to which his long services gave him a claim, even if this appointment cannot be regarded as adding materially to the reputation of the school or the strength of its staff.

PROCEEDINGS OF SOCIETIES.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

THURSDAY EVENING, MARCH 8, 1877.

The PRESIDENT, DR. H. LENOX HODGE, in the chair.

Heart showing anomalous arrangement of the leaflets of the pulmonary valve, these being four in number. By Dr. J. C. WILSON.

THIS heart, which is enormously enlarged and dilated, was removed from the body of T. M., an Irish laborer, fifty-five years of age, who died in my ward at the Philadelphia Hospital, February 8, 1877, of granular and fatty degeneration of the kidneys, with general anasarca and effusions into the serous cavities.

The man's death occurred ten days after his admission to the house, the clinical history of the case whilst it was under observation being the description of the ultimate dyscrasia of such renal affection.

I omit it, for the reason that the specimen is shown simply as an illustration of the valve-malformation.

The heart weighs twenty-five and a half ounces. Both ventricles are dilated, the right greatly so. The wall of the left is considerably, that of the right slightly, thickened. The mitral and tricuspid valves are but little changed; the aortic semilunar valves are thickened, and small masses of calcareous matter are situated in the sinuses behind them.

The pulmonary valve is composed of four semilunar segments. Of these, three are quite normal in appearance and of nearly equal size; the fourth, which lies between the posterior and the right lateral segments, is somewhat less than half the width of the others, but of nearly the same depth. Like them it has a distinctly symmetrical convex marginal attachment to the wall of the artery, and when carefully examined upon the handle of a scalpel shows a slight thickening at the middle of its free margin, which corresponds to the corpuscle of Aurantius. There are elongated slit-like fenestrations near its edge, such as are often encountered in valves otherwise normal. The sinus of this little extra valve communicates with that of the posterior leaflet. In June, 1876, I exhibited to the Society a similar specimen. In that heart, as here, the fourth leaflet was smaller than the others, but like them in shape and outline, especially as regards its free margin and the margin of attachment. It occupied the same position as in this specimen, namely, between the posterior and the right segments.

It was on that occasion suggested by Dr. Pepper that the malformation was due to some antecedent morbid process, by which the long posterior segment had formed a linear adhesion to the wall of the artery, and thus been divided into two parts. After the fresh opportunity for study afforded by the analogous specimen before us, I am convinced that this is not the case. On the other hand, the anatomical completeness of the small fourth segment, its symmetrical outline, its faintly-marked but distinctly-recognized corpuscular thickening in the middle of the free edge, and the entire absence of similar disease-signs in the parts immediately adjacent on the right side of the heart, all indicate the origin of this rare malformation in the processes of specialization of points in early fœtal life by which the valves are formed.

Henle alludes to the infrequent occurrence of such supernumerary valvelets, and Pea-

cock, in his book on Malformations of the Heart, has collected several cases.

Encephaloid cancer of the lymphatic glands of the neck. By Dr. R. A. Cleemann.

Twenty-eight months ago a woman of nervous temperament, fifty-five years of age, consulted me in regard to a small pendulous growth on the left side of the face, which had existed there several years. Being annoyed by the resulting disfigurement, she had lately tied a ligature about it, a measure which had led to its partial strangulation. I separated what remained of the pedicle, and the little ulcer that was left healed kindly. A year subsequently (sixteen months ago) she showed me an ovoid nodule, situated just behind the angle of the jaw on the same side occupied by the former growth. She stated that this already existed at the time the first little tumor was removed; it was then a small "lump," rolling under the skin, and gave her no pain, but had since grown much larger, and within a short period had caused her so much suffering as to destroy her night's rest. The pain was described as extending over the whole side of the head and into the ear. My examination revealed a movable mass of the shape mentioned above, hard to the touch, and apparently tender. I estimated it to be nearly two inches in its longer, and about one and one-half inches in its shorter, diameter. The skin over it was reddened, an effect, perhaps, of the hot poultices she had been applying. Two months afterwards (fourteen months ago) the tumor had diminished to less than one-half the last-mentioned size. It was still hard, but was now more irregular in contour, as though separating into lobules. The patient, on being questioned as to the fact, said she had noticed a tendency in the "lump" to increase and then diminish. A week ago she consented to have the growth removed. It had grown larger again, and was the seat of lancinating pains of great severity. Exposure to the cold irritated it, as well as the contact of woollen wrappings. It made her life miserable. The skin over it had now become closely adherent, and was of a deepened hue; its surface was obscurely cleft and uneven. It seemed to extend deeply behind the maxilla.

The tumor, as removed, is seen to be about the size and somewhat the shape of an English walnut, one and one-fourth inches in its longer, and about three-fourths of an inch in its shorter, diameter. Its seat was in the subcutaneous cellular tissue, but it had encroached upon the parotid gland, so that it was thought prudent to excise a portion of this along with it. Its structure, like a congeries of enlarged lymphatic glands, in gross appearance is very similar to that of a firm encephaloid growth which I presented to the Society a short time ago, the latter being recurrent to a mixed encephaloid and epitheliomatous tumor of the integument.

Whether there is any connection to be traced between this morbid mass and the little pendulous tumor of the cheek is not certain. If the patient is correct in saying that they were coexistent, it seems likely that an effect of the strangulation was to enlarge the affected glands by simple irritation, and that a cancerous process was afterwards developed there. But if there was an interval between the appearance of the growths, then it is more probable there was an element of malignancy in the sphacelated tumor of the cheek. An interesting feature, as obscuring the diagnosis of the nature of the growth, was the variation in its dimensions clearly distinguished by me.

Report of the Committee on Morbid Growths.

A microscopical examination of the specimen presented by Dr. Cleemann shows a circumscribed collection of epithelial cells, arranged in alveoli. The stroma constituting the walls of the alveoli is very scanty in proportion to the amount of cellular elements. The new formation may be classed among the carcinomata, variety encephaloid.

March 22, 1877.

Acute carcinoma of breast. By Dr. John Ashhurst, Jr.

The specimen is one of rapidly-growing cancer of the breast, removed by operation from a married woman forty-four years of age. The duration of the disease has been seventeen months, and the tumor, which was of unusually large size, involved the pectoral muscle, a considerable portion of which was removed (laying bare the ribs and intercostal spaces), as were also several lymphatic glands in the infra-axillary region. The operation was performed on January 27, and the after-progress of the case had been complicated by the occurrence of secondary hemorrhage on the fifteenth and sixteenth days, and of a sharp attack of pleurisy on the nineteenth day; but the patient survived these risks, and at the date of the report was thoroughly convalescent.

Dr. Nancrede has made a microscopic examination of the growth, and found it to present the characteristic appearances of encephaloid cancer.

Osteo-sarcoma of femur. By Dr. John Ashhurst.

This specimen of osteo-sarcoma of the right femur was removed by hip-joint amputation from a young man twenty-two years of age. The disease first appeared fourteen months previously, above the inner condyle of the femur, and rapidly increased in size, spreading upwards, also, towards the groin, until at the time of the operation the whole thigh was enormously enlarged. The tumor was quite hard, the superjacent tissues being tightly stretched over it, and the subcutaneous veins much distended. The circumference of the diseased (right) limb was twenty-six and a half inches, and that of the left limb only six-

teen inches. Amputation at the hip-joint was performed on February 28, and the progress of the case since then has been perfectly satisfactory. The weight of the tumor, after all the soft parts had been removed, was fourteen pounds.

A microscopic examination of the peripheral portion of the growth, made by Dr. Nancrede, showed the tumor to be a sarcoma, the prevailing elements being round and spindle-shaped cells, though no doubt the deeper portions would have been found to contain myeloid or giant cells as well.

A plaster cast is also exhibited, showing the appearance of the limb before amputation.

Carcinoma of stomach, pancreas, mesentery, etc. By Dr. W. H. PARISH.

J. M., a German, æt. 64 years, and a ragpicker by occupation, was admitted to the St. Mary's Hospital February 13, 1877. His mother died of a tumor of the neck; his father of some lung-affection, probably phthisis.

His own health had been fair until July, 1876. Since then there has been a gradual loss of appetite and an increasing emaciation. Constipation, pyrosis, and vomiting were among the earlier symptoms, and became more and more aggravated. At the time of admission to the hospital the emaciation had become extreme, and there was a decided cachectic appearance. There was vomiting of everything taken into the stomach, and constipation of twelve days' duration. There was some œdema of the lower extremities; at times pain in the epigastric region, but at no time severe. In the region of the stomach and extending below it, and also in the region of the left lobe of the liver, was a decided tumor, firm and resisting in character, but somewhat movable. There were a number of small masses easily distinguished on palpation, and seemingly very superficial The tumor was slightly painful when manipulated. There were no ascites. The superficial abdominal veins were decidedly enlarged.

After removal of the constipation and restriction to liquid diet, the vomiting became only occasional, the water-brash remaining persistent. Owing to the extreme emaciation and the marked symptoms, although there was never vomiting of blood, the diagnosis seemed easy, and was that of carcinoma of the stomach, especially the pyloric portion, and a similar involvement of the mesentery and most probably of the pancreas and left hepatic lobe. Death occurred on the 28th of February, of asthenia.

The *autopsy* was made by the resident physician, Dr. Garrett.

In the pericardium was about an ounce of serous fluid. The heart-valves were normal. In the right ventricle, and extending to the bifurcation of the pulmonary artery, was a firm white clot. Old adhesions in both pleuræ. Hypostatic congestion of lungs. In the upper lobe of the left lung was a small hard nodule. In the left lobe of the liver there were several fine nodules. The rest of the liver seemed normal in appearance. The spleen and right kidney were normal. The left kidney gave evidence of cystic degeneration. There was no albumen in the urine. The tumor on removal was found to consist of the stomach, pancreas, portion of the omentum, and mesentery. The mesenteric glands are greatly enlarged and dense in character. The pylorus is decidedly encroached upon by the indurated growth. The growth seems not to involve any of the stomach but the immediate neighborhood of the pylorus. There is no appearance of ulceration of the mucous surface of the stomach. The abdominal aorta and the inferior vena cava were embraced by the cancerous omentum.

A microscopical examination was made by Dr. S. H. Griffiths, whose report is subjoined.

"I present herewith a brief description of the microscopical appearances of the specimens of stomach, pancreas, and mesenteric gland submitted by you.

"*Stomach.*—A section presented an alveolar structure; the alveoli filled with round and distorted cells. The meshes were in some parts large, much broader than the bands of intervening fibrous tissue. Other portions were made up in greater part of the dense fibrous stroma; these would be found in close proximity to the former, and contained small nests of shrivelled or granular cells. The cells varied in size from $\frac{1}{3000}$ to $\frac{1}{800}$ of an inch in diameter, and contained vesicular nuclei and distinct nucleoli.

"Sections of the *pancreas* showed a marked increase of the interlobular connective tissue, which was intermixed with spindle-shaped cells. No nests of large cells were found.

"The *mesenteric gland* was made up of delicate trabeculæ, the large meshes of which were filled with cells, some with lymph-corpuscles, but mostly with large cells; everything densely packed.

"*Conclusions.*—Stomach, scirrhus; mesentery gland, soft carcinoma; pancreas, not determined."

Death from embolism in diphtheria. By Dr. JOHN M. KEATING.

J. B., æt. 35, was under treatment in the Philadelphia Hospital for acute articular rheumatism for some time. The joints most affected were the ankles and the wrists. The attack finally became subacute, and he was obliged to remain in the hospital on account of the inability to do much walking. He had had no inflammation of the cardiac membranes, nor had any murmur been detected during the rheumatic attack.

Two days before his death he called my attention to his throat, which he said was painful and the muscles felt stiff upon deglutition. I found the pharyngeal arches red, swollen, and covered with patches of grayish mem-

brane. He had slight fever, and complained of great weakness, though at the time I saw him he was walking about the ward. The most active treatment was immediately instituted: beef-tea, quinia, iron, absolute rest, and an application of tinct. ferri chl., salicylic acid, potass. chlorat., and glycerine, made to the throat. That evening his condition was somewhat improved. Early the following morning the resident physician, Dr. Philips, was called, and found the patient comatose, pulseless, cold, respirations exceedingly rapid, and the heart beating with great rapidity and irregularity. The symptoms all pointed to heart-clot.

The specimens which I show this evening were removed immediately after death. The clot, which is white, hard, and very large, existing in the right ventricle, extends through the venæ cavæ, and throughout the whole venous system; that in the left heart is smaller, but of the same character, and is prolonged not only through the ramifications of the pulmonary vein, but into the aorta and its branches. The suddenness of the attack, its severity, and the rapidity with which almost complete coagulation of the blood took place, have an especial interest in the fact that the patient was rheumatic.

REVIEWS AND BOOK NOTICES.

Transactions of the American Gynæcological Society. Vol. I., for the Year 1876. Boston: H. O. Houghton & Co., Cambridge Riverside Press. 1877.

Organized amid the whirl and bustle of last summer, the American Gynæcological Society bids fair to realize the brightest hopes of its founders. Its first volume of Transactions, now before us, will bear the closest scrutiny, and safely challenge the severest criticism, so superior is it in its breadth of thought and observation, scientific worth, and literary excellence; the writers of the papers in these Transactions being no mere novices, but men skilled in the profession they represent, and experts in the branch of study and practice which they especially call their own.

The annual address by the President, Dr. Fordyce Barker, is a model in its way,—scholarly, eloquent, and hopeful. The papers of the English members—Drs. Barnes, Duncan, Wiltshire, and Tait—are excellent examples of the style and mode of thought of those well-known workers and writers. The paper of Dr. Barnes, on "The Relation of Pregnancy to General Pathology," fairly teems with suggestive ideas. No man can peruse it without an enlargement of his mental vision. The rude practitioner of the country-side and the polished consultant of the city can alike in its pages find food for thought.

Three papers—Dr. Duncan's, on "Central Rupture of the Perineum," Dr. Skene's, on "Cicatrices of the Cervix Uteri and Vagina," and Dr. Goodell's "Clinical Memoir on some of the Genital Lesions of Childbirth"—should be read consecutively, forming an admirable group, showing how disastrous these lesions are to the future health and comfort of our patients, how best they may be avoided, and how, if inevitable, we may mitigate the evils they entail.

Dr. James R. Chadwick gives a "Case of Labor complicated by Uterine Fibroids and Placenta Prævia," and has collected seven additional cases, forming a valuable addition to the literature of the subject. Dr. Byford's paper on "The Spontaneous and Artificial Destruction and Expulsion of Fibroid Tumors of the Uterus" strives to show, by studying nature's procedure, the path which science should pursue. The discussion following this paper, as most of the papers, possesses a value second only to that of the article itself.

The three papers about which opinions will most differ are "Pneumatic Self-Replacement in Dislocations of the Gravid and Non-Gravid Uterus," by Dr. Henry F. Campbell, "Extirpation of the Functionally Active Ovaries," by Dr. Robert Battey, and "Latent Gonorrhœa with Regard to its Influence on Fertility in Woman," by Dr. Emil Noeggerrath. The first of these papers is a full examination of the postural method of treatment in displacement, and is worthy of a careful study. The accompanying discussion will show how diverse the views of the acknowledged experts may be as to the propriety or necessity of a frequent resort to this method. The operation suggested and performed by Dr. Battey has been already brought before the notice of the profession by him, under the name of "Normal Ovariotomy." In the present paper he enters upon a labored defence of this term. His argument seems to us, after a careful reading, an excellent one—to prove that "normal ovariotomy" is a misnomer, and that he should have called it "the operation for the removal of apparently normal ovaries," a legitimate conclusion which he totally disclaims, while he deeply laments that in abandoning this term he can find no other equally good. Referring to his own quotation from Dunglison (p. 111) of the definition of normal as "according to rule, perpendicular," we out of sheer pity suggest "perpendicular ovariotomy," as the "more tenderer" name.

The views of Dr. Noeggerrath will, we presume, find but few enthusiastic advocates. The writer endeavors to sustain his theory by cases and statistical reasoning of a somewhat limited character. For an able examination of these statistics we refer the curious reader to the remarks of Dr. Chadwick.

There have been of late years various attempts to explain what has been termed "the early decay of American women,"

and "the dying out of the American race." Now, without committing ourselves to the view that such a decay exists,—which would be eminently unpatriotic,—we certainly have been supplied with a wealth of explanations of the assumed fact. The M.D., not of Harvard, who doubts the benign influence of the Hub, says, "Too much education! Too much brain-culture!" The foreigner — probably French—who has spent a week in the streets of New York, reading in the faces of our women the secret—revealed to him alone—of their ill health, suggests "bad habits." "The prevalence of criminal abortion," whispers the sensational physician and equally sensational divine. "The habitual prevention of conception," add their hearers, whose ears are itching. The climate is accused by some, — "the American race not acclimated;" the diet by others,—"too little bran in our bread, too much meat, too little mastication." The advocate of advanced ideas in feminine dress says, "Tight lacing, and the weight too much on the hips;" while "high-heeled shoes" is the modest suggestion of the thoughtful student whose relative carries on the anatomical shoe business. But these theories are evanescent. Gonorrhœa alone is eternal. Let those only who have cured it blush in silence, for by the passage of an olive-pointed bougie its existence in a latent state can be proved even in the most thoroughly cured. These latent things are always dangerous, and men having latent gonorrhœa, if married to healthy women,—according to our author,—speedily infect them; not always with the acute disorder, but with uterine catarrh, perimetritis, and ovaritis; and gleet, "like a worm i' the bud," will gnaw not only on the hitherto blooming cheeks of its victims, but will steal its sinuous course through their cervical canals and their uterine cavities and their fallopian tubes till they become sterile.

We would suggest that many blooming though not irreproachable women have suffered from successive gonorrhœas and retained their bloom, and have subsequently married and had children, unless the researches of the late Mr. Acton are of no value. But perhaps there is something in *latent* gonorrhœa more deadly. Can we conceive that the well-known writer is slightly tainted with homœopathy, and views a gleet as a diluted triturated two-hundredth-potency-infinitesimal disease, the more powerful since its particles are the more finely divided?

Dr. Johnson, in the discussion of the paper, struck at the root of the matter, and we may as well say that the evidence presented by him shows an heroic self-sacrifice on the part of our ever noble profession, for he stated that he had conversed with twenty physicians who had had the disease in early life, were married now, and who pointed triumphantly to wives not faded, and families numerous enough to put all idea of sterility to flight. Such statistics, secured by such heroic self-abnegation, should surely outweigh the statistics of Dr. Noeggerrath.

Space, not inclination, prevents a mention of the many other papers of interest. No medical man will regret the purchase of this volume. E. W. W.

GLEANINGS FROM EXCHANGES.

THE TREATMENT OF DIPHTHERIA (*The Clinic*, June 2. 1877).—Dr. Luzinsky (*Allg. Wiener Med. Zeitung*), at the close of a series of papers on Diphtheria, expresses his conclusions aphoristically, as follows:

1. Diphtheria and croup are essentially one and the same disease, and only differ in their local manifestations, or rather in the names given to these.

2. Diphtheria is a general disease, consisting in a peculiar morbid state of the blood, with a tendency to fibrous coagulation in and upon various organs.

3. The origin of diphtheria is miasmatic, its contagiousness not being demonstrated.

4. The life of the patient in diphtheria may be threatened in either of the following ways: the original morbid alteration of the blood, the localization of the exudation in organs necessary to life, the breaking down of the exudate and renewed blood-infection, exhaustion, anæmia, uræmia, or paralysis.

5. With all these dangers, the course of diphtheria is sometimes so mild as to need no medical intervention or assistance.

6. At other times all remedial measures are in vain.

7. In many cases, however, the disease may be successfully combated if the symptoms are properly taken into account.

8. In the treatment of diphtheria, the abnormal tendency to fibrinous coagulation and exudation is to be remembered, and met with solvent substances, as alkalies, principally carbonate of soda and chlorate of potash.

9. The exudation must be prevented or limited by the application of cold, the use of astringents, and removal of the pseudo-membranes.

10. When the diphtheritic exudate is localized in the larynx, trachea, or larger air-tubes, inhalations of solvent fluids are to be adopted.

11. Emetics are only of use when loose exudative masses collect in the air-passages.

12. Tracheotomy only promises good results when the exudation is confined to the larynx, the bronchi and lungs remaining unaffected; it is otherwise to be tried in every hopeless case, even if only with the object of procuring euthanasia.

FEATS AND TRAINING.—The *Lancet*, apropos of the Oxford-Cambridge boat-race, makes the following sensible remarks, editorially: The annual display of muscular prowess by

young men principally devoted to intellectual pursuits is always interesting,—in senses wholly apart from the claim it possesses on public attention as an "event." The feat excites emotions of triumph, the training gives rise to more or less serious misgiving, and the phenomenon of men doing good brain-work, also achieving great results in other departments of energy, must awaken reflections which it is well should be stirred in every thoughtful mind. In principle a perfectly developed man should be good all round. His powers of mind, of muscle, and of special sense should be in a high degree excellent. It is, doubtless, a physiological fact that when only one part of the organism is developed, to the neglect and, therefore, at the expense of others, not only is the integrity of the system as a whole, but, in a special degree, that of the peculiar faculty or faculties cultivated, impaired. The early and signal collapse of men who have only been trained to intellectual pursuits, and know nothing of muscular exercise, has read the world a useful but too little heeded lesson on that point. Meanwhile there is grave peril in excessive training, and violent explosive exertion either of body or mind. Undue training enervates in the end; and an excessive strain on the powers of action, even though it last less than half an hour, may leave lifelong injuries behind.

Treatment of Acne (*Canada Medical Record*, May, 1877).—M. Rodet, of Lyons, prescribes the following treatment in acne. Friction is to be made every evening over the acne papules, with the following ointment:

℞ Adipis, ℥v;
Sulphuris,
Tannin, āā gr. viij ad xv.—M.

In the morning the face is to be bathed with warm water, to which a little bay rum has been added, the proportion being increased from day to day until it amounts to one-third.

M. Doyen, of Lyons, recommends bathing with the following:

℞ Aq. destillat., f℥x;
Hydrarg. bichlor., gr. xxx;
Tinct. lavanduli, f℥iiss.—M.

M. Hardy uses this formula:

℞ Aquæ, f℥x;
Potassii sulphuret.,
Tinct. benzoini, āā ℥iiss.—M.

Two teaspoonfuls in a glass of warm water to be used externally. For the treatment of acne erythematosum (*couperose*), Hardy suggests the following:

℞ Hydrarg. protiod., gr. iss ad ii;
Ung. aq. rosæ, ℥iv.—M.

Six Cases of Latent Syphilis in the Fathers of Healthy Children are reported by Dr. J. Güntz, of Dresden, in the *Vjhrschr. f. Dermatol. u. Syph.*, and *Schmidt's Jahrbücher*, No. 2, 1877. In each of these six cases, at least two years had elapsed since the latest manifestations of the disease, before marriage. In several cases the first child was born syphilitic, the second healthy. In all of the cases, within a few years after the birth of their children, the deeper syphilitic lesions manifested themselves in the persons of the fathers, all of whom had had good reasons, in the birth of healthy children, to suppose that the disease was eliminated from their systems.

Rupture of the Spleen, with Recovery (*Canada Medical Record*, May, 1877).—According to the *St. Petersburger Med. Zeitschrift*, a physician, 33 years of age, after an attack of typhus fever, and seventeen days of convalescence, had four short but sharp exacerbations of fever, in which the spleen became larger than at any time during his illness. After a severe fit of vomiting, symptoms of rupture of the spleen, with internal hemorrhage, set in; the pain in the epigastrium was intense and paroxysmal: an increased area of dulness was manifested about the enlarged spleen, and there was collapse. The symptoms of extending dulness and collapse increased, the temperature sank, and there were cyanosis and suppression of urine. Bladders of ice were applied to the abdomen, and a grain of opium was given every three hours, and finally subcutaneous injections of camphor were tried, and enemata of port wine. On the following day there were no symptoms of peritonitis, and at length there was absorption of the extravasation and general improvement, terminating in recovery. The seriousness of the accident may be judged from the fact that, of twenty-two similar cases, conducted by Kerner, all died.—*Berl. Klin. Woch.*, 4, 1877.

A Supposed Ether Death (*The Medical Press and Circular*).—A case of *soi-disant* death from ether is reported by a contemporary to have occurred in the London Hospital. That it was not in any degree fairly chargeable to the anæsthetic is evident from the conditions observed before and after death. We are told that the patient had been for three days vomiting from strangulation of intestine, and "was so much exhausted that it was a question how far he could bear any operation." A large admixture of air with the ether vapor was permitted, and, as a consequence, "he did not take it well, and struggled much."

On post-mortem examination, the heart was found flaccid, and left ventricle uncontracted: "the lungs were extremely emphysematous, and the bronchi filled with muco-purulent matter."

It is obvious that the patient was moribund when placed on the operating-table, and that his death, while half under the influence of the ether, was a simple coincidence.

Almost all the cases of death attributed to ether seem to have arisen from respiratory disease; it will be necessary, therefore, for anæsthetists to give more attention to the lungs and bronchi in the examination previous to administration of ether.

MISCELLANY.

MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA.—The twenty-eighth annual session of this Society, just held, numbered one hundred and eighty-four, and was the largest meeting held for years, except the one of 1876, at Philadelphia. The entertainments and receptions were most bounteous, but no intoxicating liquors were to be had either at the private repasts or at the public banquet given by the Dauphin County Medical Society. Prof. D. Hayes Agnew was elected president for the ensuing year; and it was resolved to hold the next annual meeting at Pittsburg.

ACCORDING to the London *Lancet*, the sanitary condition of the Turkish army is very bad, in spite of the admirable arrangements of the camps. The troops are execrably provisioned, and medical care is almost null in the field, and even in the hospitals "often abominable." Scurvy and typhus have both made their appearance. In the Russian army, on the other hand, although there is a great tendency among the privates to get drunk, the great care and foresight of the officers have borne abundant fruit. As an instance, it is mentioned that two regiments of three thousand men each had only conjointly one hundred and three men in the hospital after a forced march of two hundred and fifty miles.

THE SANITARY INFLUENCE OF THE EUCALYPTUS.—At the Sorbonne, recently, some information was given by Dr. De Pietra Santa as to the importance and value of the Eucalyptus globulus in relation to public health. It appears that reports were received by the Climatological Society of Algiers from fifty localities where the aggregate number of blue-gum trees is nearly one million, and from these reports the following conclusions have been drawn:—(1) It is incontestably proved that the Eucalyptus possesses sanitary influence; for (2) wherever it has been cultivated, intermittent fever has considerably decreased, both in intensity and in frequency; and (3) marshy and uncultivated lands have thus been rendered healthy and quite transformed. Similar results have been obtained in Corsica, where it is computed that at the end of the present year there will be upwards of six hundred thousand plants of eucalyptus in full growth.—*Medical Press and Circular.*

ABNORMAL APPETITE.—In reporting the death of an imbecile at the work-house, the chairman of the Bristol Board of Guardians narrated an extraordinary incident. The deceased's idiosyncrasy was to put anything that he could get into his mouth. For years past he had a special appetite for the blankets and rugs supplied him as bed-covering. The deputy-chairman said the deceased had consumed upon the average a large woollen rug every three weeks, and in consequence of this the guardians had directed that a supply of bread should be always kept alongside of him, so that he might indulge his propensity for eating in a legitimate way; but in the intervals between meal-times he rejected the bread and persisted in eating blankets.—*British Medical Journal.*

DEATH FROM TWENTY GRAINS OF CHLORAL.—Dr. E. E. F. Ingalls (*Chicago Medical Journal and Examiner*) reports that he gave to a German woman, about 33 years of age, apparently healthy, ten grains of hydrate of chloral, repeated in one hour. Soon after the second dose the patient manifested alarming symptoms of poisoning, and died, in spite of all efforts, in about fifteen minutes. No post-mortem examination was made. The patient had taken only two doses of chloral, of ten grains each, an hour apart.

THE editor of the *St. Louis Medical Journal* asserts that the "hell-hounds" are on his track. We are glad they have got so far West.

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY FROM JUNE 17, 1877, TO JUNE 30, 1877, INCLUSIVE.

HEAD, J. F., SURGEON AND MEDICAL DIRECTOR.—Granted leave of absence for one month, S. O. 121, Department of the South, June 16, 1877, and leave extended one month. S. O. 135, Division of the Atlantic, June 21, 1877.

BAILY, J. C., SURGEON.—Assigned to duty as Post-Surgeon at Benicia Arsenal, California. S. O. 66, Division of the Pacific and Department of California, June 15, 1877.

GRAY, C. C., SURGEON.—Assigned to duty at Fort Riley, Kansas. S. O. 115, Department of the Missouri, June 16, 1877.

BACHE, D., SURGEON.—In addition to his present duties, to attend the sick at Alcatraz Island, California. S. O. 68, Division of the Pacific and Department of California, June 20, 1877.

WOLVERTON, W. D., SURGEON.—Assigned to duty at Fort A. Lincoln, D. T. S. O. 77, c. s., Department of Dakota.

WOODHULL, A. A., SURGEON.—Relieved from duty at Alcatraz Island, California, and assigned to temporary duty at Camp Halleck, Nevada. S. O. 68, c. s., Division of the Pacific and Department of California.

WHITEHEAD, WM. E., ASSISTANT SURGEON.—Assigned to duty at Fort Larned, Kansas. S. O. 115, c. s., Department of the Missouri.

VICKERY, R. S., ASSISTANT-SURGEON.—Assigned to temporary duty at Fort Schuyler, N. Y. H. S. O. 142, Division of the Atlantic, June 28, 1877.

DE WITT, C., ASSISTANT-SURGEON.—Assigned to temporary duty at Omaha Barracks, Nebraska. S. O. 87, Department of the Platte, June 26, 1877.

SEMIG, B. G., ASSISTANT-SURGEON.—Assigned to duty as Post-Surgeon at Camp Bidwell, California. S. O. 66, c. s., Division of the Pacific and Department of California.

MAUS, L. M., ASSISTANT-SURGEON.—Assigned to duty at Standing Rock Agency, D. T. S. O. 77, c. s., Department of Dakota.

TORNEY, J. H., ASSISTANT-SURGEON.—Relieved from duty in Department of the Gulf, and to report to the Commanding General Department of the Missouri, for assignment. S. O. 135, A. G. O., June 15, 1877.

NEWLANDS, WM. L., ASSISTANT-SURGEON.—To report to Major George B. Sanford, 1st Cavalry, for duty with his command. S. O. 68, c. s., Division of the Pacific and Department of California.

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THE COLLEGIATE YEAR is divided into three Sessions:—A Preliminary Session, a Regular Winter Session, and a Spring Session.

THE PRELIMINARY SESSION will commence September 19, 1877, and will continue until the opening of the Regular Winter Session. It will be conducted on the plan of that Session.

THE REGULAR WINTER SESSION will commence on the Third of October, 1877, and end about the 1st of March, 1878.

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THE SPRING SESSION embraces a period of twelve weeks, beginning in the first week of March and ending the last week of May. The daily Clinics, Recitations, and Special Practical Courses will be the same as in the Winter Session, and there will be Lectures on Special Subjects by the Members of the Post-Graduate Faculty.

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THE PRELIMINARY AUTUMNAL TERM for 1877–1878 will open on Wednesday, September 19, 1877, and continue until the opening of the Regular Session. During this term, instruction, consisting of didactic lectures on special subjects and daily clinical lectures, will be given, as heretofore, by the entire Faculty. Students expecting to attend the Regular Session are strongly recommended to attend the Preliminary Term, but attendance during the latter is not required. *During the Preliminary Term clinical and didactic lectures will be given in precisely the same number and order as in the Regular Session.*

THE REGULAR SESSION will commence on Wednesday, October 3, 1877, and end about the 1st of March, 1878.

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Fees for Tickets to all the Lectures during the Preliminary and Regular Term, including Clinical Lectures,	$140.00
Matriculation Fee	5.00
Demonstrator's Ticket (including material for dissection)	10.00
Graduation Fee	30.00

FEES FOR THE SPRING SESSION.

Matriculation (Ticket good for the following Winter)	$5.00
Recitations, Clinics, and Lectures	35.00
Dissection (Ticket good for the following Winter)	10.00

Students who have attended two full Winter Courses of Lectures may be examined at the end of their second course upon Materia Medica, Physiology, Anatomy, and Chemistry, and, if successful, they will be examined at the end of their third course upon Practice of Medicine, Surgery, and Obstetrics only.

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WILLIAM L. RICHARDSON, M.D., *Instructor in Obstetrics.*
THOMAS DWIGHT, M.D., *Instructor in Histology.*
EDWARD S. WOOD, M.D., *Professor of Chemistry.*
HENRY H. A. BEACH, M.D., *Assistant Demonstrator of Anatomy*
WILLIAM H. BAKER, M.D., *Instructor in Gynæcology.*
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SAMUEL G. WEBBER, M.D., and JAMES J. PUTNAM, M.D., *in Diseases of the Nervous System.*

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Instruction is given by lectures, recitations, clinical teaching, and practical exercises, distributed throughout the academic year. The year begins September 27, 1877, and ends on the last Wednesday in June, 1878. It is divided into two equal terms, either of which is more than equivalent to the former "Winter Session," as regards the amount and character of the instruction. The course of instruction has been greatly enlarged, so as to extend over three years, and has been so arranged as to carry the student progressively and systematically from one subject to another in a just and natural order. In the subjects of anatomy, histology, chemistry, and pathological anatomy, laboratory work is largely substituted for, or added to, the usual methods of instruction.

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Students are divided into three classes, according to their time of study and proficiency. Students who began their professional studies elsewhere may be admitted to advanced standing; but all persons who apply for admission to the second or third year's class must pass an examination in the branches already pursued by the class to which they seek admission. Examinations are held in the following order:—

At the end of the first year—Anatomy, Physiology, and General Chemistry.

End of second year—Medical Chemistry, Materia Medica, and Pathological Anatomy.

End of third year—Therapeutics, Obstetrics, Theory and Practice of Medicine, Clinical Medicine, Surgery, and Clinical Surgery.

Examinations are also held before the opening of the School, beginning September 24.

REQUIREMENTS FOR A DEGREE.—Every candidate must be twenty-one years of age; must have studied medicine three full years, have spent at least one continuous year at this school, have passed the required examinations, and have presented a thesis.

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